Joint MPH Program

University of Gondar and Addis Continental Institute of Public Health

ASSESSMENT ON ACCEPTABILITY OF PROVIDER INITIATED HIV TESTING AND COUNSELING AMONG TB PATIENTS IN ZEWDITU MEMORIAL AND St. PETER HOSPITALS

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Table of contents

List of Abbreviations

AIDS - acquired immune deficiency syndrome

ART - Antiretroviral Treatment

DHS - Demographic health survey

E.C - Ethiopian Calendar

EPI- Expanded Program of Immunization

FHAPCO – Federal HIV/AIDS program control organization

FMOHE - Federal Ministry of Health - Ethiopia

FY - Fiscal Year

Hans's HIV aids specialized nurse

HCT - HIV counseling and testing

HIV - Human Immunodeficiency Virus

JHPIEGO- Johns Hopkins program for international Education in Gynecology and obstetrics

MOH - Ministry of Health

OPD - Out patient department

PICT - Provider initiated testing and counseling

PLWHA - People living with HIV/AIDS

PMTCT- Prevention of mother to child transmission

TB - Tuberculosis

UN - United Nations

UNAIDS –United nation AIDS

VCT - voluntary counseling and testing

WHO - World Health Organization

ZMH- Zewditu Memorial Hospital

List of Tables

List of Figures

Abstract

Increased access to HIV testing and counseling is essential to promoting earlier diagnosis of HIV infection, which in turn can maximize the potential benefits of life-extending treatment and care, and allow people with HIV to receive information and tools to prevent HIV transmission to others.

Objective: This study was conducted in March and April 2009 to assess acceptability of provider initiated HIV testing and counseling and associated factors among patients in TB clinic in Addis Ababa.

Methodology: Institutional based cross sectional study was conducted and 178 patients were interviewed. Only two patients refused. To validate the data 15 patients were interviewed and the same result was obtained. In-depth qualitative interviews were conducted to find out the reasons for the high acceptance of PITC.

Results: All patients were initiated HIV testing and Counseling by the health providers. Among 193 patients to whom HIV testing and counseling were initiated only three patients did not accept the test. In depth qualitative interview reveled that all patients accepted the test. PITC trainings, facility level implementation action plans, contextual plans based on site staff adequacy, infrastructure, system and coordination, integrated with other health topics and increased awareness of patients could be the reasons for the high acceptance rate.

Conclusion and recommendation: Almost universal acceptance of HIV testing and counseling is achieved in health facilities. In order to maintain the same level PITC must be strengthened and expanded in all facilities at all levels.

1. Introduction

1.1. Background information

Progress has been made in recent years in global efforts to deal with the acquired immune deficiency syndrome (AIDS) epidemic, including increased access to effective treatment and prevention programs. However the number of people living with human immune deficiency virus (HIV) continues to grow, as does the number of death due to AIDS in the past. A total of 33.2 million people were living with HIV in 2007. In many regions of the world, new HIV infections are heavily concentrated among young people (1)

Surveys in twelve high burden countries in Sub-Saharan African showed that a median of just 12% of men and 10% of women in the general population had been tested for HIV and received their results. Greater knowledge of HIV status is critical for expanding access to HIV treatment, care and support in a timely manner, offer people, living with HIV, the opportunity to receive information and tools to prevent HIV transmission to others(2).

Two thirds (68%) of all adults and children with HIV globally live in sub-Saharan Africa and continues to bear the highest share of the global HIV epidemic. Almost three quarters (76%) of all adult and child deaths due to AIDS in 2007 occurred in sub-Saharan Africa: that is about 1.6 million of the global total of 2.1 million deaths (4). According to the adjusted single point HIV prevalence estimate published by the federal HIV/AIDS control office; about 2.1% of Ethiopia's adult population was living with HIV 2007. It was projected that the prevalence would remain the same till 2007, and then would rise to 2.2%, 2.3% and 2.4% in 2008, 2009 and 2010 respectively. In 2007, nearly a million people were living with HIV of which 59.1% were females, with

infection levels more than eight times higher in urban than in rural areas (7.7% versus 0.9%).(3,4)

Some treatment programs have reported high early mortality in patients receiving antiretroviral therapy because of late presentation. Therefore, early detection of HIV infection is not only useful in preventing further infection but also part of strategy to improve treatment outcome. Though VCT has been used for several years in many setting still it is not enough even to identify those who need subsequent treatment and care. In line with this a new approach is being introduced namely routine counseling and testing of patients, also called provider-initiated testing and counseling (PITC) (2).

HIV counseling and testing (HCT) is the key entry point to prevention, care, treatment and support services, where people learn whether they are infected and are helped to understand the implication of their HIV status and make informed choice in the future. There has been widespread concern about the slow uptake of voluntary counseling and testing (VCT) in many parts of sub-Saharan Africa still, in many high-prevalence countries, fewer than one in ten HIV positive individuals are aware that they are infected with the virus. Some treatment programs have reported high early mortality inpatients receiving antiretroviral therapy because of late presentation.

Early detection of HIV infection is not only useful in preventing further infection but also part of strategy to improve treatment outcome. However, Coverage of client-initiated HIV testing and counseling services is inadequate in both high-income and resource-constrained settings. WHO and UNAIDS strongly support the continued scale up of client-initiated HIV testing and counseling (5) It would be, therefore, imperative to conduct an assessment of acceptability of provider Initiated HIV counseling and testing among TB patients in TB clinic to help improve the uptake based on the envisaged outcome.

This research envisages reduction of expense to treat OIs, bed occupancies and increase quality of life and productivity by early detection through PITC.

2. Literature Review

2.1 TB/HIV co-infection

Ethiopia is one of the highly affected countries by the TB/HIV co epidemic. The WHO global report 2008 estimates that in Ethiopia 40% of TB patients tested for HIV are HIV positive, while routine data from 1999 EFY (2006/7) estimates that 31% of TB patients are HIV positive (6). TB is a major cause of death among people living with HIV/AIDS. Sub-Saharan Africa bears the brunt of the HIV fuelled TB epidemic. The rapidly increasing HIV epidemic in other parts of the world could also increase the number of HIV-related TB cases (7). TB specific mortality is fourfold higher among HIV-infected patients than among the uninfected patients (9)

The dual epidemics have a number of impacts on the health sector. They increase TB and HIV burden, demand for care and worsen the situation of the already overstretched health care delivery system in the country. Therefore, tuberculosis and HIV prevention and control programs share mutual concerns: Prevention of HIV is a priority for tuberculosis control and prevention and care of TB are priority concern for HIV/AIDS prevention and control program (6).

Moreover, the health workers should strongly recommend and routinely offer HIV testing for all TB patients and TB suspects after providing them with adequate information on the benefits of HIV testing (6,8) The World Health Organization estimates that in 1999 there were 33.6 million people infected with HIV worldwide and about a third of these were infected with Mycobacterium tuberculosis. HIV infection is the strongest risk factor for both reactivation of latent tuberculosis and for progression

from primary infection with M. tuberculosis. (9) Tuberculosis is the oldest of the world's current pandemics and causes 8·8 million new cases and 1·6 million deaths annually. The disease is among the most common causes of morbidity and mortality in people living with HIV. However, tuberculosis is more than just part of the global HIV problem; well-resourced tuberculosis programs are an important part of the solution to scaling-up towards universal access to comprehensive HIV prevention, diagnosis, care, and support. This article reviews the impact of the interactions between tuberculosis and HIV in resource limited settings; outlines the recommended programmatic and clinical responses to the dual epidemics, highlighting the role of tuberculosis/HIV collaboration in increasing access to prevention, diagnostic, and treatment services; and reviews progress in the global response to the epidemic of HIV-related tuberculosis (TB) is the leading cause of morbidity and mortality of HIV-infected people in developing countries. One study reported that 30–40% of deaths of HIV-infected people are caused or contributed to by TB (10). HIV-infected individuals are more susceptible than HIV-uninfected persons to acquiring TB after exposure to Mycobacterium tuberculosis and to activation of latent infection. (11)

2.2 HIV counseling and Testing (HCT)

Surveys in sub-Saharan Africa have shown that a median of just 12% of men and 10% of women had been tested for HIV and received their results. (2) WHO and UNAIDS strongly support the continued scale up of client-initiated HIV testing and counseling, but recognize the need for additional, innovative and varied approaches (5). Health facilities represent a key point of contact with people with HIV who are in need of HIV prevention, treatment, care and support. Health care workers should strongly

recommend and routinely offer HIV testing for all TB patient and TB suspect, after providing them with adequate information on the benefit of HIV testing (6). Evidence from both industrialized and resource-constrained settings suggests that many opportunities to diagnose and counsel individuals at health facilities are being missed and that provider-initiated HIV testing and counseling facilitates diagnosis and access to HIV-related services. (2) Tuberculosis (TB) patients are one of the target populations for the PITC (12) The WHO has, therefore, incorporated routine counseling and testing as a component of TB/HIV collaborative efforts (13). Subsequently, the National TB and HIV guideline in Ethiopia recommends HIV counseling and testing as a routine care for TB patients (6).

The document recommends an "opt-out" approach to provider-initiated HIV testing and counseling in health facilities, including simplified pre-test information, consistent with WHO policy options developed in 2003 and with the 2004 UNAIDS/WHO Policy Statement on HIV Testing.

With this approach, an HIV test is recommended: - for all patients, irrespective of epidemic setting, whose clinical presentation might result from underlying HIV infection as, a standard part of medical care for all patients attending health facilities in generalized HIV epidemics; and more selectively in concentrated and low-level epidemics. (2)

Countrywide, after the adaptation of the PITC strategy, it was implemented in different situations, particularly for those patients with tuberculosis and sexually transmitted infections. Some studies were undertaken to assess willingness and acceptability of clients on this regard. However, the diagnostic approach is not only meant for those with tuberculosis and sexually transmitted infection, but also for those with other possible

signs of HIV infection like weight loss and chronic diarrhea. On the other hand, there is scarcity of information on PITC in the country on this regard.

The five year plan of Ethiopian HIV/AIDS (FY 2004-2008) is that by 2008, approximately 50% of Ethiopians over 15 years of age will know their HIV status through the routine and/or voluntary counseling and testing (14) But according to DHS 2005 report among the adult population of age 15-49 years, only 4% of women and 6% of men have been tested for HIV at sometime (15) HCT services in Ethiopia have been uneven and even when available uptake has been relatively low.

The three types of HIV testing in Ethiopia are the Client initiated, or voluntary counseling and testing, provider initiated testing and counseling (PITC) and mandatory HIV screening. PITC targets patients presenting with symptoms or signs of illness possibly attributable to HIV, it is a basic responsibility of the health care providers to recommend HIV testing and counseling as part of the routine clinical management(5). Jhpiego in October 2005 in partnership with the government of Ethiopia, the US government through the president's emergency plan for AIDS relief (PEPFAR) and several other implementing partners introduced PITC in TB clinics in Ethiopia (16). Before the introduction of PITC, less than 10% of TB patients were tested for HIV. After the introduction of PITC, more that 90% of TB clients were offered an HIV test, with 80% acceptance of HIV testing. During the first six months of PITC services, there were significant increase in the number of TB patients receiving counseling and testing, and in the number of people receiving referral for care and treatment. Of the 2936 TB patients who were offered an HIV test, 2594 accepted. Of those tested, HIV prevalence was 44.8% (1163), and 94% (1098) of those who tested + for HIV were referred for care and treatment service. The pilot project demonstrated that PICT is an effective strategy for reaching individuals at high risk of HIV infection as well as for identifying people

who are eligible for treatment because people with active TB are almost by definition treatment eligible (16).

Another study also conducted in Arba Minch, Ethiopia to assess acceptability of PICT among patients in January-August 2005 revealed that 73% were willing to be tested and 58% of those willing accepted the test. The overall acceptability rate was 35%. Fourteen (20.6%) were HIV positive (17).

Study also conducted in October 2005 by ICAP (International center of AIDS care and treatment Program) in eight hospitals supported by ICAP. Among 317 new TB patients of unknown HIV serostatus were registered at the TB clinics of the hospitals where the PITC progress was reported 75/317(24%) received counseling and testing services.

By December 2006, of 626 new TB patients of unknown serostatus, 530(85%) received HCT and 65(12%) were HIV-infected. This showed that over a period of one year and six months the proportion of new TB patients counseled and tested for HIV increased from 24% to 85% (18). In our study PITC offered to 193 TB patients and out of these 190/193(98.4%) accepted PITC. A study which was published in Ethiopian Public Health Association, Extract No4, 2008 showed that willingness to accept PITC was 86.2% (19).

Another study on PITC in Nairobi Kenya which was published on December 16, 2008 showed that from 2262 TB patients who were offered PITC 2050 (91%) patients had accepted the test (20). PITC assessment was done by NATIONAL HIV COUNSELING AND TESTING TECHNICAL WORKING GROUP and indicated that all of the health facilities provide PITC. The most common place of delivery for PITC was TB clinic (100%) followed by medical OPD (95%), anti natal clinic (89%), Labor and delivery (83%), medical inpatient (63%), emergency OPD (61%) and STI clinic (55%). Seventy

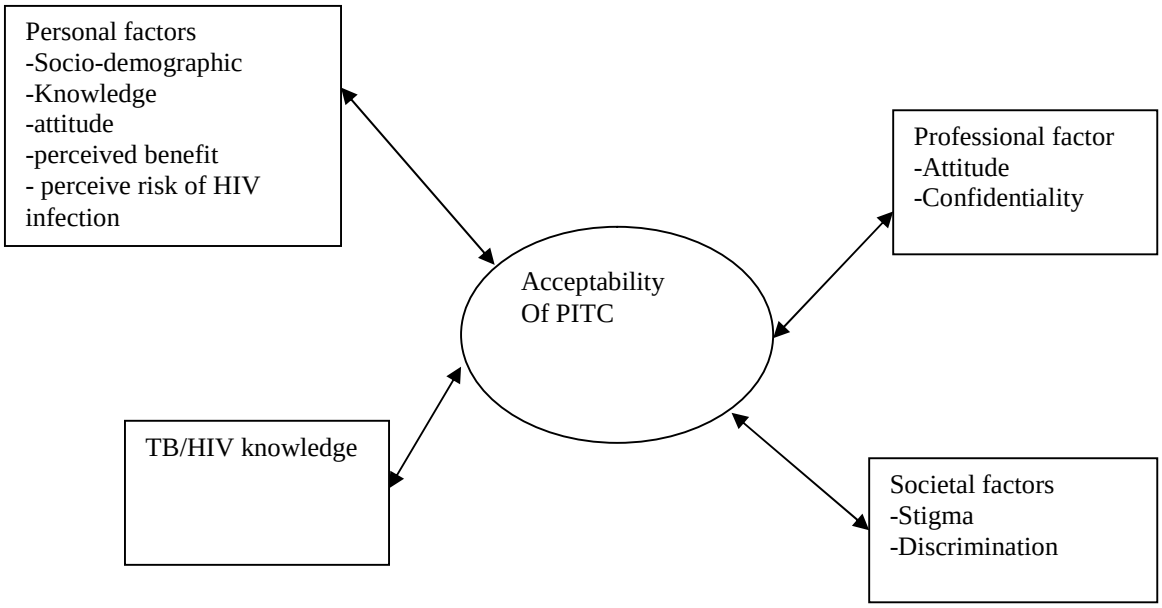
two percent of the health facilities offered PITC as a standard medical care for all patients attending their health (21).

Therefore the aim of this study was to assess uptake of PITC among TB patients in the health facilities of the hospitals under consideration because PITC is an effective strategy for early diagnosis and treatment. After determining the prevalence of HIV among TB patients and assessing PITC acceptability, the result of the study would be used for further scale up of the strategy at all levels.

3. Conceptual framework of PITC

As shown in figure 1 there are numbers of factors that influence acceptability of PICT. The factors include personal characteristics; professional attitude and influence; patient knowledge of the two disease and their relationship; and societal factors such as stigma and discrimination. Although there are empirical evidence suggesting that all these factors are important in effective implementing PITC in Ethiopia a comprehensive assessment has not been conducted and this study does not claim to be comprehensive, but it tries to shade some light in this area.

Figure 1 Conceptual framework for Studying Acceptance of PITC in a TB clinic Addis Ababa, Ethiopia



4. Objective

4.1. General

To assess acceptability of provider initiated HIV testing and counseling among patients in TB clinic in Addis Ababa, Ethiopia.

4.2 Specific

1. To determine the proportion among patients presenting for TB services and accepting PITC.
2. To determine factors influencing the acceptance of PITC
3. To assess whether approach to PITC is more yielding than the current all client approach.

5. Methodology

5.1. The study Area.

The study was conducted in Addis Ababa, Ethiopia with an estimated population of 2.4million in which the adult HIV prevalence rate is 7.9 %(3). In the city there are 36 hospitals out of which five are under Addis Ababa health bureau, four are under federal ministry of health and one hospital is under Addis Ababa University and 22 privately owned.

There are public ART sites, hospitals and health centers. PLWhiv who have started with ART in the city since July 2003 were 36,380. Currently 142,419 patients are on ART (26).

The study was conducted in Zewditu memorial and St. Peter hospitals. These hospitals were selected because they provide comprehensive care for huge number of patients.

a) Zewditu Memorial Hospital:

The hospital is located in kirkos sub city. The hospital was the first ART site in Ethiopia that started giving HIV care by providing HIV counseling and testing for TB patients and for patients with sign and symptoms of HIV infection since 1991(E.C). In July 2003, the hospital started providing free based ART service for patients from all corners of the country based on the national treatment guideline. There were also free patients from Addis Ababa, who could produce a free paper from their place of residence.

Since the launch of free ART, service in March 2005, the clinic is providing HIV care for more than 5000 HIV infected patients coming from different parts of the city. The clinic is currently staffed with 2 physicians with laudable experience in providing HIV care and treatment and 8 advanced HIV nurses and adherence counselors, 1 pharmacist, 4 druggists, number of lab technicians, 4 data clerks, 1 data manager and 5 Adherence supporters to trace patients who are lost to follow ups through telephone and home visits. The ART clinic in the hospital is well staffed and has good medical recording system.

Based on the ART registration log book from the total 6000 patients on ART 6.6% of patients have developed TB. Moreover, among the total TB patients currently being followed at the TB clinic, the prevalence of HIV is estimated to be around 40% (unpublished data, Zewditu Hospital HIV Clinic, 2009).

b) St. Peter Hospital:

The outpatient section of the hospital was established in 1961G.C and was named TB Demonstration and Training Centre. The construction was made by the government and furniture, medical equipments and medications were supplied by UNICEF and WHO. The outpatient department is located in kolfe Keranio Sub city near Mesalemia square, 11 Km from the inpatient department. It started service with three expat physicians and 89 in

country HCW. To give general medical services to all patients referred from all over the country using skilled manpower and state of the art technology focusing on TB. The outpatient section provides TB screening, diagnosis and referral, Paediatrics, HCT/ART and vaccination for yellow Fever and Meningococcal meningitis for international travellers. It has Outpatient and Inpatient department and diagnostic and drug supply services (pharmacy, laboratory, radiology and pathology, FNA). The outpatient and inpatient have merged in 2000 and are under a single administration under Federal MoH and named St Peter TB Specialized Hospital. The Hospital has three main objectives: health services, training and research. Free ART is started in the outpatient department on Meskerem 11, 1998 (September 21, 2005).Currently 1296 patients have already started ART and 2287 have been enrolled into care. ART service launched in the inpatient section too. With JHU's support the Hospital recently launched ANC and PMTCT service. More than a thousand and eight hundred patients have accessed ART from this facility in just over two years time. The facility has good intra facility linkage with all the OPD's (Tb clinics), VCT/PITC and also with the inpatient department .PITC is a standard activity in the facility with good TB/HIV collaboration.

The Study Process

This study has both quantitative and qualitative components. Initially the study was designed to be only quantitative. However, the assumptions made for the qualitative study were not found in reality. The high of PITC acceptance at the study TB clinics prompted a different research question than it was originally designed. Thus, two additional steps were added: first a special investigation by the principal investigator was made to make sure that the observed data actually reflects the reality. For that the principal investigator observed about fifteen clients- provided interactions and interviewed about the same number of clients. This provided evidence that in fact PITC acceptance rate is high. Once

that was verified to continue collection until the calculated sample size is achieved was meaningless. Then, the research question and objectives were reframed to address whether an alternative high risk approach is more productive than inviting everyone for PITC using quantitative approach and to explore the reason for high acceptance using qualitative methods. The study also faced serious challenges in getting access to public health facilities for data collection that forced the researcher to change a research site. The details of both quantitative and qualitative methodology are given in separate sub-section below.

5. 2. Quantitative component

5.2.1 Study design

Facility based cross sectional study was conducted among patients in TB clinics to assess acceptability and uptake of provider initiated HIV testing and counseling in Addis Ababa**.**

5.2.2 Sample Size

As this is a cross sectional study, a single population proportion formula, $n= Z\alpha^2/2\ p\ (1-p)/d^2$ was used to estimate the sample size of clients to be interviewed. Based on the study which was conducted in 2005 by Jhpiego rate of PITC was 80% .I took the proportion of PITC acceptance 80% (p= 0.8), level of significance=0.05 marginal of error (d) = 5%. With those assumptions, the sample size was calculated and the overall sample size was found to be 246. Then 10% contingency for non –response was added and the final sample size was decided to be 271 TB patients in the TB clinic.

5.2.3 Sampling Procedure

Data were collected from two purposefully selected health facilities providing comprehensive TB and PITC services in Addis Ababa. The study planned to recruit a total of 271 TB clients based on probability proportional to sample size procedure from Zewditu and Tikur Anbessa

hospitals, which makes 200 and 71 patients were supposed to be interviewed respectively. However the proposed data collectors in Tikur Anbess hospital demanded high compensation that was beyond the capacity of this small research project. Because of this, the study site was changed to St. Peter hospital. Thus, the time lost during the process of negotiation permission for the study and the significant reduction in client flow in Zewditu Hospital forced the research team to abandon the PPS method and recruit patients as they come to the two facilities.

5.2.4 Source population:-

The source populations for this study were all patients presented to the two TB clinics seeking services related to TB diagnosis and treatment who are above the age of 14.

5.2.5 Study Population:

The study population includes TB patients who visited the health facilities during a six week study period.

Inclusion criteria: Patients referred for the diagnostic work-up, patients already with known TB diagnosis and on treatment and follow-up with missed opportunity to PITC, age above 14 years and those who were willing to participate in the stud**y.**

Exclusion criteria: The exclusion criteria were: Patients with previously known HIV status, patients less than 14 years of age and patients unwilling to participate in the assessment.

5.2.6 Data collection:

Data collection questionnaire was prepared (adopted from previous similar studies and modified). The main content of the questionnaire were consent form, socio demographic variables, knowledge on and attitude of TB/HIV/AIDS, personal risk perception and knowledge about PITC. Facility clerks who were currently working in the hospital as

monitoring and evaluation staff after receiving one day training collected the data by interviewing patients on exist from the clinic. Nurses from TB/HIV clinic were recruited from the selected hospitals and trained for the same period to serve as supervision. The training focused on how to fill the questionnaire properly and solicit consent from potential study participants.

Data collectors participated in a pre- testing session at St. Paul Hospital TB clinic for one day. From the information we got from the pre-test we have modified our approach. The two TB/HIV trained nurses at the respective hospitals and the investigator supervised the data collection and check filled questionnaire for consistency and completeness. The interview was carried out on appointment days in which patients came to treatment to the centers.

5.2.7 Study variables

The dependent variable of the study was acceptability of PITC and the independent variables were socio- demographic characteristics of clients including age, sex, religion, marital status, educational status and income.

5.2.8 Data processing and analysis

Data were entered into EPI Info data processing software by the researcher and latter transformed onto SPSS version 15.0 for further analysis. Frequency distribution percentages for selected variables were calculated.

5.2.9 Data quality assurance

Training was given for data collectors and supervisors. For four data collectors one supervisor was assigned to supervise the data collection on a daily basis and check the completed questionnaire for consistency, clarity and completeness.

5.3. Qualitative component

5.3.1 Design: As described above the qualitative component was an add-on component to specifically address the reasons for high acceptance of PITC. The qualitative component used in-depth interviews.

5.3.2 Study subjects: Clients who come to the TB clinic of the hospital and health care providers working at TB clinic were recruited for in-depth interviews.

5.3.3 Sample size: The sample size for the qualitative study was not decided at the beginning. It was decided in the field based on how much the research question is answered. Saturation and redundancy of information has set the limit to the number of interviews. Twenty patients and five health care workers from the two hospitals were involved in the interview. The decision to stop data collection was made because no new information was obtained in the last few interviews; which is technically referred as saturation.

5.3.4 Data collection; Open ended interview guides were used to conduct interviews. All interviews were conducted in Amharic by the principle investigator. In- depth interviews were conducted to obtain information on the PITC service. The interview guide tried to understand the process of consent for PITC: were patients pressured to accept PITC, was there any chance given to the patient to say no, and if the patients regretted after the test. It was a one to one interview conducted in Amharic and patient communicated very well. Participants were selected mainly because they were willing to spare some more time with the study team. All of the Interviews were done in a quite separate room where the privacy of the participants was protected. All of the interviews were tape recorded with the permission of the participants. All patients who were asked to be interviewed were willing; there was no refusal.

5.3.5 Data Analysis: The qualitative data was also transcribed from the audio taped records. The transcription was made in Amharic. After complete transcription of interviews data were coded manually in Amharic. Thematic analysis approach was used for data analysis.

5.4 Operational Definition

PICT- Provider initiated HIV testing and counseling refers to HIV testing and counseling which is recommended by health care providers to persons attending health care facilities as a standard component of medical care.(4)

VCT – (also called Voluntary Counseling and testing, or VCT) involves individuals actively seeking HIV testing and counseling usually emphasizes individual risk assessment and management by counselors, addressing issues such as the desirability and implications of tacking an HIV test and the development of individual risk reduction strategies. (4)

Acceptance- measured by the proportion of TB patients gets tested and hear their final results (given post test counseling)

Acceptors: TB patients who accept PITC.

Non- acceptors: TB patients who do not accept PITC

5.5 Ethical Consideration

The study was approved by the ethical committee of ACIPH & University of Gondar. A support letter from ACIPH was obtained; the letter explained the purpose of the study and was useful in facilitating data collection. A verbal consent was obtained from each respondent. Patient was informed that, no name was registered, the document would be coded, and the information would be kept confidential and would be used for study purpose only. The patient was assured that the interview was on voluntary basis and the right to withdraw any time during the interview.

6. Results:

Socio-demographic profiles:

From the quantitative result fifty point eight percent (58.8%) of the study participants were male with nearly one to one ratio (1.03:1 male to female ratio). Majority in the qualitative study were females. The majority of participants in the quantitative study were in the age range between 25 and 29 (20.7%). From the Quantitative data most (66.8%) of those interviewed were Orthodox Christians followed by Muslim, (19.2 %). Regarding the marital status of the participants 43.3% were married, 39.9% were single and 6.7% were divorced. Eleven point four read and writes, twenty eight percent (28%) secondary educations, twenty eight percent above secondary education and nine point eight(9.8%) were illiterates. Twenty nine point nine percent (29.9%) of the respondents were civil/private servants, thirteen percent (13%) were daily laborers, twelve point four (12.4%) were students and thirteen percent were house wives.

Knowledge and attitude towards TB/HIV/AIDS

All study subjects (193) reported that they have heard of HIV/AIDS and 189/193(97.9%) believed that HIV is definitely not a curable disease. Almost all respondents knew that sexual intercourse and sharing of sharp materials respectively were the most common ways of HIV transmission. Significant number of respondents was able to identify mother to child transmission during pregnancy 132/193. Overall, 22/193(10.9%) of the participants had misconception on transmission of HIV/AIDS including mosquito bite, and sharing a meal with person living with HIV/AIDS.

Among 193 study participants (100%) reported that they have heard of HIV /AIDS, 138/193 (71.5%), 166/193, (86%) of the participants indicated that abstinence and staying with only one uninfected partner as means of HIV prevention method

respectively. Out of 193 respondents 166, (86%) also mentioned use of condom every time during sexual intercourse as means of HIV prevention method.

Seventy eight point eight percent of participants believed that HIV infection could be asymptomatic, and 79.8% reported that they knew someone infected with HIV or died of AIDS.

Regarding patients' knowledge on tuberculosis: 189/193, (97.9%) of the participants believed that tuberculosis is a curable disease, and 125/193(64.8%) of the study subjects said that they revealed their TB status. Only 21.8% of patients were afraid of being infected with TB before they were diagnosed. From the in depth interview it was found that most of the patients were motivated and encouraged to let others know their health status. One respondent said that *"he will definitely disclose his status for his wife because it is a family disease?"* However few respondents were not ready to share their test result because of stigma and discrimination one patients said "*there are people who don't listen to the radio and have no information about HIV and may stigmatized and discriminate TB/HIV patients".* From 193 study respondents 183(93.3%) responded that the source of TB was from TB patients and, 134/193 (69.4%) from polluted air. Others reported from evil spirit 3/193, (1.6%).

Table 1: Socio-Demographic Characteristics of Tuberculosis Patients who visited ZMH and St.Peter hospitals in Addis Ababa March-April 2009

Socio-demographic Characteristics		Number	Percent
Age	15-19	14	7.3
	20-24	36	18.7
	25-29	40	20.7
	30-34	20	10.4
	35-39	39	20.2
	40-45	23	11.9
	>46	21	10.9
Sex	Male	98	50.8
	Female	95	49.2
Religion	Orthodox	129	66.8
	Muslim	37	19.2
	Protestant	25	13.0
	Catholic	2	1.0
Marital Status	Married	84	43.5
	Never Married	77	39.9
	Divorced	13	6.7
	Widowed	10	5.1
Education Status	Illiterate	19	9.8
	Read and Write	22	11.4
	Primary Education	43	22.3
	Secondary Education	54	28.0
	Above Secondary	54	28.0
Occupation	Daily Laborer	25	13.5
	House Wife	25	13.5
	Student	24	12.4
	Civil Servant	28	14.5
	Merchant	31	16.1
	No Job	22	11.4

Table 2: Tuberculosis patients' Knowledge and Attitude Related to TB/ HIV/AIDS and perceived risk of HIV infection in Addis Ababa March to April 2009

TB/HIV/AIDS Relate Question**	Number	%
Source of TB:		
From TB patients	180	93.3
Polluted air	134	69.4
Contaminated Water	8	4.1
Health personnel/health unit	70	63.7
Having Sexual Contacts	1	.5
Evil Spirit	3	1.6
Route of HIV transmission		
Sexual contact	192	99.5
Sharing of sharp materials with PLWHA	136	70.5
Mother to child by breast feeding	131	67.9
Transfusion of blood	150	77.7
Mother to child during pregnancy	132	68.4
Blood contact	91	47.2
Mosquito Bite	10	5.2
Methods of HIV prevention		
Abstinence	138	71.5
Staying with only one uninfected partner	166	86
Use of condom every time during sexual intercourse	167	86.7
*Chance of getting infected with HIV		
High	23	12.4
Moderate	11	7.3
Minimal	52	39.4

* Majority f the respondents did not answer the question regarding the chance of getting infected with HIV.

**Multiple Responses were possible for all questions.

PITC acceptance

Of the total 178 patients that were interviewed for the purpose of the study only two patients refused PITC; PITC acceptance rate of 98.8%. No patient refused participation in the study.

At the PITC acceptance rate is extremely high the possibility of doing internal comparison to identify between acceptors and non acceptors was nullified. Therefore, effort was refocused to validate the result. The principal investigator conducted fifteen patients. Among the fifteen patients the investigator found only one patient who refused PITC. Then the research focused on doing a qualitative study to find out reasons for such high up-take of PITC service. From the qualitative study, all patients who were interviewed accepted PITC. Both quantitative and qualitative results showed that the acceptability of PITC is high. The reasons for this high PITC acceptability as per the response of the interviewee were the presence of health education in the facilities and from mass media, good relation ship with providers, peer experience one respondent said that in the waiting area "*there are PLWhiv sharing their experience"* and as due respect for the providers that offered the testing. One respondent said that we believe health care providers as our God father "*we respect their words*". Some patients had already under gone testing or heard about PITC during their last clinic visits and hence accepted the test without hesitation. One patient said "*now VCT centers are available everywhere and the test does not take weeks as it was before you can have your result within thirty minutes"*. **Some of the respondents said that** "*PITC service is good to know our health status, plan for the future and help prevent others and as it is a family disease majority of patients said they will disclose their test for their family members especially for their spouse"* However some patients claimed that there was some pressure from the HCP for their acceptance.

One patient said *"I am not prepared to have the test but I did any way because the provider influenced me.*"The other participants also added *"being tested by initiation of the provider disturbs because it is a sudden offer and no time to think"* The other patients said they are strong in counseling once they start counseling they don't let you out without testing "*They know how to counsel"* One client said "*in client-initiated testing there is no fear but in provider initiated testing and counseling it seems as if mandatory and it creates discomfort"*. *The* other respondent *said "I have to obey the advice of the Doctor"*.

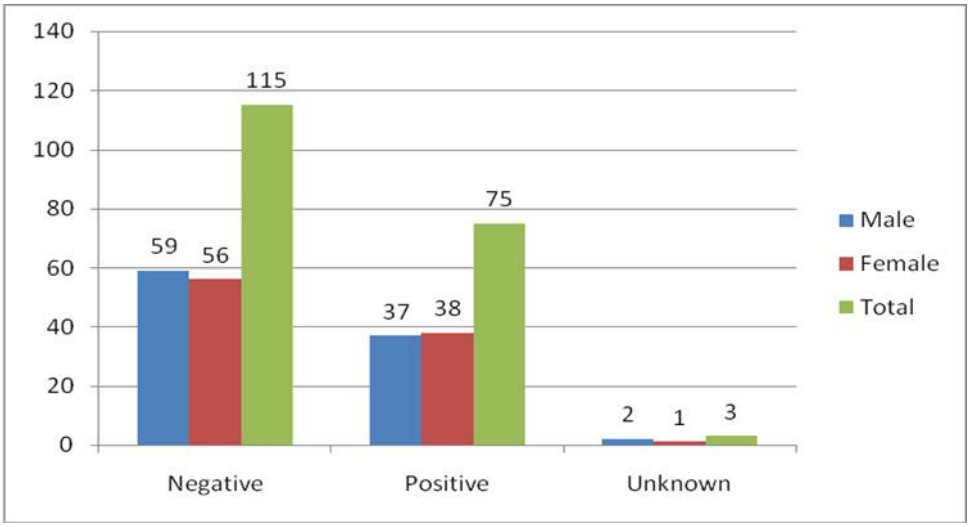
During the interview the providers said that "*PITC and Rapid testing training is provided on site continuously for all health care providers. This has contributed the ability of the provider to initiate and motivate the patient to accept PITC"*.

As a response to the patients argument, the providers explained that they influence patients for the benefit of the patient: One provider said that *"the initiation was sudden and the patients tend to refuse but we tried to convince them by telling them advantages and disadvantages of PITC we do not want to miss even one patient with out getting PITC service"*. The other provider said that we told them that if some one has TB he definitely has HIV. During the interview with a patient it was reveled that some patients had no chance to say no. One patient said that *"I was not given a chance to say no, I was very much scared because no proper counseling except group information at the waiting area and most of the time we didn't pay attention, but after knowing my result I was very happy*". The other patient said that "*the provider told me we need to see your blood result and it was so sudden and I even haven't had time to think and say no"*.

Results from the in-depth interview no regrets or disappointments were observed after conducting the test, rather they were relived and were very happy they made the right decision to be tested regardless of the result.

All of the participants had accepted PITC. Out of 190 patients 75/190 (38.9%) were positive and females were 38 and males were 37 which is almost 1:1 ratio. The rest 3/193 (1.5%) did not accept PITC. They believed that they are not risk persons for HIV.

Graph 1 HIV status of TB patients who received PITC in the two hospitals.



Assessment of Risk Approach to PITC

If acceptance is so high we thought it would be better to test only TB patients who reported high risk perception would give a better result. So we did a bivariate analysis to see whether there is any association between risk perception and HIV test results.

As shown in Table 5, there was no association between the reported risk perception and HIV result. Comparing reported high risk as a screening approach with the HIV test as gold standard revealed: specificity of 26%; sensitivity of 70.6%, and positive predictive value of 38.4%. OR of 0.85 also shows no association between HIV risk perception and HIV test result. Thus, the alternative approach of using reported high risk as screening would result in more cases undetected. Hence, we need to provide PITC for all TB patients regardless of their risk perception.

Table 3 Relationship between HIV test result and reported high Risk perception among TB patients who received PICT. Addis Ababa, Ethiopia. 2009

		HIV Test Result	
		Positive	**Negative**
Reported High Risk Behaviors	**Yes**	53	85
	No	22	30
OR (95% CI)			0.85 (0.42, 1.71)
Specificity			26.%
Sensitivity			70.6%
Positive predictive value			38.4.3%

Knowledge and attitudes towards PITC

Of the 193 patients interviewed, 170/193 (88.1%) reported that they are aware of the availability of PITC before this interview. The most common source of information for PITC mentioned by participants were health worker 153/193 (79.3. %), and mass media 112/193 (58. %) followed by family members and friends 26.4%, 34.2 respectively. The other source was from school and home based care providers (6%). Qualitative study supported the above findings; the most common source of information for PITC is from health workers and friends as one of the respondent said. "*I heard about HIV testing when my friend was talking last time. He heard it on the radio and he was saying he also wanted to have himself and his family checked when he comes to the health center*." The other respondent added "*I heard on television that those with cough should be checked*

for TB. And I heard that patients with TB can be affected with HIV additionally. And when my doctor provided the testing, I was ready to take it."

Ninety seven point four percent were extremely or very much in favor PITC. Most of the participants (97.4%) believed that PITC is important. Among those who believed PITC is important 71.5% said that it makes easier for TB patients to get tested and majority agreed that PITC helps to gain access to ART (63.2%). From the qualitative study majority of respondents accepted PITC without any hesitation one patient said "*PITC is good because I would not have the courage to test myself without their support"*. This further confirms that they are in favor of PITC. The clients also mentioned the benefit of PITC as hope for their future life and protection of others. One respondent said that "in previous years there were many deaths but now the death is not as it is before I think this is because of the availability of PITC" The other respondent said that "it is a gift of God if I have HIV I will plan for my future, my children and take the medicine it is available everywhere we see people getting fit after the medication.

Table 4: Knowledge and Attitude Related To PITC among Tuberculosis Patients in ZM and St. Peter hospitals Addis Ababa, March - April 2009 (Multiple Responses were possible)

Variables	Frequency	%
Sources of information for PICT		
Mass media	112	58.0
Health worker/ institution	153	79.3
Friends	66	34.2
Family member	51	26.4
Others**	6	3.1
In favor of PITC		
Yes	188	97.4
No	2	12.4
No Response	3	7.3
Reason for PITC is important:		
Helps TB patients to get access to ART	122	63.2
Makes easier for TB pts to get tested	138	71.5
Results in less discrimination	46	23.8
Increases number of tested people	90	46.6

** School, HBC

HIV Testing among Tuberculosis Patients

From the quantitative result it was found that 193 (100 %) of the sampled TB patients have got PITC information in the waiting area. Among 193 study participants 190 were tested and received their results. 97.9% were tested during their TB treatment and significant number of patients had tested for HIV before being diagnosed for TB, during pregnancy, for marriage and for visa. Qualitative study also supported the above result, most of the patient who were participated in the in-depth interview had under gone HIV test before. One respondent said that "HIV testing is common and people are discussing freely especially when the two people are getting married." The other respondent said my family advised me if you have TB accept the doctors advise to test HIV. One respondent also said that if I have only TB it is very simple to be cured but if I have TB with HIV very difficult to be cured but now a day they come together."This showed majority of the patients have Knowledge of TB/HIV.

The provider said that "*when patient hesitate to accept PITC we explained to them that if some one has TB he will have fifty percent chance of having HIV then they accept."*

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SUMMARY of RESULTS FROM IN-DEPTH INTERVIEWS WITH HEALTH CARE PROVIDERS

Five nurses were involved in the interview. All of them were trained for PITC. They have been working in TB clinic of their respective hospitals more than three years. All of them said almost all of clients were satisfied with PITC service.

They said client and provider relationship is very good. It is like brothers and sisters. However, most of them attribute satisfaction of clients to satisfaction in relation to the quality of life gained by clients after PITC. Patients who are found positive were immediately referred to HIV clinic for follow up.

All of the respondents confirmed that the acceptance of PITC is high in the TB clinic of the two hospitals. Some of the providers worried that the PITC may not be fully addressed in sustainable and effective manner because of shortage of the required manpower. This has been confirmed by the provider during the interview that many of the patients had to leave without being initiated or tested because of shortage of man power. The one provider also said that "*we do not want to miss even on patient to leave without having the PITC service.*"

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7. Discussions

Health facilities represent a key point of contact with people with HIV who are in need of HIV prevention, treatment, care and support. Health care workers should strongly recommend and routinely offer HIV testing for all TB patient and TB suspect, after providing them with adequate information on the benefit of HIV testing. Provider initiated testing and counseling (PITC) is designed in such a way that it will increase the number of HIV positive individuals enrolled into HIV care programs. As starting ART early before much damage to immunity system occurred improves survival and quality of life, and as many people are not accessing HIV counseling and testing service (HCT) via VCT, the introduction of PITC was found to be timely and very important for the HIV/AIDS prevention, care and treatment programs of Ethiopia. The number of persons of ART and chronic HIV care has significantly increased especially in facilities with strong PITC service provision.

The results of this study demonstrate the acceptability of PITC among TB patients. All patients were initiated for HIV testing by their TB treatment supervisor and 190/193 (98.4%) accepted the test. All of the HIV tested patients had received their HIV test result.

In this study, high proportions of TB patients were aware of TB; curability of TB (97.9%) and source of TB from TB patients (93.3%).

In this study, all TB patients reported that they have heard of HIV/AIDS knowledge on mode of HIV transmission and prevention indicated the facts that most of the TB patients had the correct knowledge. On the other hand, still few (5.2%) of the participants had misconception on transmission of HIV/AIDS like mosquito bite and sharing of meal with people living with HIV.

In our study, there was widespread support for PITC, with 97.4% of TB patients reporting that they were either extremely or very much in favor of PITC. A majority of respondents felt that PITC would increase uptake of ARV, number of tested patients and would decrease HIV related stigma. These results, in conjunction with the high acceptability of PITC among TB patients (98.4%) this study, suggests that PITC is beneficial in improving access to testing and there by increasing life-saving treatment users.

Comparing with the study in Arba-Minch which was conducted in January-August 2005 PITC acceptability among TB patients was 35%. In October 2005 another study was conducted by Jhpiego and acceptability of PITC was 80%. In the same year study was conducted by ICAP the PITC program was reported only 24%. By December 2006 acceptability of PITC increased from 24% to 85%. A study which was published in Ethiopian Public Association, Extract No4, 2008 showed that willingness to accept PITC was 86.2%.(19).

Another study was conducted by ICAP Dil-Chora referral Hospital the acceptance of PITC was high 80%, Augments the overall PMTCT program in the country, identifies HIV exposed infants early and provides an access HIV care and treatment service to women. (22)

In December 16, 2008 study in Nairobi Kenya showed that acceptability of PITC increased to 91%. (20)

In this study PITC acceptability is found to be 98.4%. When we see the trend of PITC acceptability in this study it has increased from the previous years. As per my observations there are multiple factors which could contribute for this result such as involvement of NGOs in staff training, supportive supervision and Mentoring in the

implementation of point of care testing which enables the patients to be tested and counseled in the same room by the same staff.

Assessment findings of National Provider Initiated HIV Testing and Counseling Implementation Status April 2009 showed that PITC service in TB clinic is 100% followed by PMTCT. This Implementation status study is in favor of our study findings.

To triangulate the findings of PITC acceptability from the quantitative study qualitative study was conducted using In-depth interview the findings complement each other. Quantitative study was conducted on acceptability of PITC on TB patients in ZM and St. Peter Hospitals. The finding was among 193 TB patients 190/193(98.4%) have accepted regardless of their educational backgrounds, age and sex.

To define the above result and to know whether the right of the patients to decline the recommendation of an HIV test was protected, if the patient regretted the test after he/she has being tested and patients knowledge on the difference between VCT and PITC qualitative study was conducted using open ended standardized Interview guide. As per the findings both quantitative and qualitative results confirm the acceptability of PITC is high.

Strength and Limitation of the Study

Strength:

1. The study was supplemented by qualitative study
2. Complete information was obtained from clients and verification done by primary investigator

Limitation:

1. No sampling procedures followed for selection of subjects
2. Observation of client- provider interaction was not made

9. Conclusion

An acceptance of PITC is very high due to knowledge and attitude towards PITC both by patients and providers. The knowledge that there is an association of TB with HIV, the close monitoring and follow up of the program as well as the different on site trainings conducted for the staff assisted for the acceptance of PITC . The increase accessibility of ART service, availability of standard guidelines and the commitment of the government also have a role. The other factor which could contribute for the high acceptance of PITC is availability of point of care testing which enables the patients to be tested and counseled in the same room by the same staff which could reduces stigma and discrimination. Sustainable supply of Rapid test kits and the shortening of the time that takes to offer and give the test result have also assisted for the acceptance of PITC. Health education and information provided by adherence supporters, PLHiv trained to work around ART and HCT service out lets, added impetus to success of the program. Influence of the different mass media and health communication campaigns has also important role.

10. Recommendations

I highly recommend PITC service to be strengthened, promoted, and be routine procedure in all health facilities, at all levels, as long as patient's right is protected. I also recommend that the MOH should play a leading role with high capacity to coordinate the program. Further we recommend that PITC service be provided regardless of risk perception. In addition there should be the required manpower and supplies in place in all facilities without disruption. The facility for point of care testing should be standardized with at most care to prevent HIV transmission to both sides. To mitigate the shortage of man power task shifting like HANS nurse and using adherence supporters, continues on site training are recommended.

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12. Annexes

12.1 Consent form that certify the respondent agreement before the interview.

Assessment of acceptability of provider initiated HIV counseling and testing among TB patients in Addis Ababa

01. Name of treatment center----------

02. Questionnaire identification number------

Introduction: My name is --------- I am representing Addis continental Institute of Public health, Addis Ababa and interviewing TB patients who follow their treatment at ---------- (name of the health institution) about the acceptability of PICT and factors influencing its uptake, among TB patients in this health facility. You are selected to be one of the participants in the study. The study will be conducted through interview. Your name is not going to be required (registered) and the information you give us should be kept confidential and will be used only for study purpose. A code number will identify every participant and no names will be used. If a report of the result is published, only summarized information of the total group will appear. The interview is voluntary; you have the right to participate, or not to participate (refuse to do so) at any time during the interview. Your refusal will not have any effect on services that you or any member of your family receives. How ever, your participation is important to fulfill the study and in order to help design appropriate TB/HIV health services for Addis Ababa and other similar setups.

Was the information/objective clear?

1. ( ) yes B. ( ) No

Are you willing to participate in the study?

2. ( ) yes B. ( ) No

Thank you!!

If the study subject agrees to participate in the study, start the interview.

3. Interviewer signature certifying that the informed consent has been given verbally.

Name----------signature----------

12.2 Questionnaire

Part one: socio-demographic variables

	Questions	Coding classifications	remark
101	How old are you at your last birthday?	Years(full yrs)	
102	Record sex of the patient	Male—1 Female—2	
103	What is your religion?	Orthodox—1 Muslim—2 Protestant-3 Catholic—4 Other(specify----5	
104	What is your current material status?	Married in union----1 Never married--------- 2 Divorced---------- 3 Widowed----------4 Unmarried couples--- 5 Too young---------- 6	
105	What is your completed educational status?	Illiterate—1 Read and write—2 Primary education—3 Secondary education—4 Above secondary—5 No response--99	
106	What is your current occupation?	Civil servant—1 House wife—2 Daily laborer—3 Domestic servant—4 Hotels worker—5 Student—6 Merchant—7 No job—8 Others(specify)—9 No response---99	
107	What is your average household income per month? (yours and your spouse)	---------- birr eth No income—1 No response--99	
108	What Is your family size?	----------in numbers No response--99	
109	Do you have any family member treated before and/or being treated now for tuberculosis?	Yes—1 No—2 I don't know--88 No response--99	

Part two: knowledge, attitude, and opinions on TB/HIV/AIDS

	Questions	Coding classifications	remark
201	Have you ever been concerned of being infected with TB?	Yes—1 No—2 No response--99	
202	As at TB patient do you reveal it to others?	Yes—1 No—2 No response—99	
203	In your opinion which segment of population is at risk of getting TB? (multiple response is possible, needs probing)	The poor people—1 Those who live with TB patients—2 People living withHIV/AIDS ---------3 Other(specify)—4 No response--99	
204	From where can someone get TB? (multiple response is possible, needs probing)	From TB patients—1 Health personnel/health unit----------2 Polluted air----------3 Contaminated water-4 Having sexual intercourse----------5 Evil spirit----------6 Other(specify)------7 No response-------99	
205	Do you believe that TB can be cured?	Yes—1 No—2 No response--99	
206	Do you think the prevalence of Tb increasing after the era of HIV/AIDS?	Yes—1 No—2 No response--99	
207	Do you think control of HIV/AIDS helps for the control of TB?	Yes—1 No—2 No response--99	
208	Have you ever heard of HIV or the disease called AIDS?	Yes—1 No—2 No response--99	
209	Can HIV be cured?	Yes—1 No—2 No response--99	

210	How is HIV/AIDS transmitted? (multiple response is possible, needs probing)	Sexual intercourse—1 Mother to child during pregnancy----------2 Mother to child during breastfeeding--------3 Transfusion of infected blood----------4 Sharing of sharps with someone who is infected(needles, etc)-5 Shaking hands a person living with HIV/AIDS-6 Wearing clothes of a person living with HIV/AIDS ----------7 Sharing a meal with a person living with HIV/AIDS----------8 Mosquito bite-------9 Blood contact-----10 Other(specify)----11 No response-------99	
211	How can people protect themselves from getting HIV/AIDS? (multiple response is possible, Needs probing)	Avoiding sex(abstinence)—1 Using a condom every time during sex----------2 Staying with only one uninfected partner faithful----------3 Others(specify)---------4 No response----------99	
212	Do you know anyone who is infected with HIV or who has died of AIDS?	Yes—1 No—2 No response--99	
213	May a healthy looking person be positive for HIV?	Yes—1 No—2 I don't know--88 No response--99	

Part three personal risk perception:

	Questions	Coding classifications	remark
301	Do you think you can get the virus?	Yes—1 No—2 No response—99	if yes go to Q.303
302	What are your chances of getting infected with HIV?	Minimal—1 Moderate—2 High—3 No response—99	
303	If the answer is moderate or high, what are the reasons?	I had multiple sexual partner—1 I had sexual contact with out condom—2 I had injection with un sterile needle—3 I had sexual contact with HIV positive person—4 Other specify—5 No response—99	
304	If your response is no to question number 301, what are the reasons	I trust my sexual partner—1 No injection with un sterile needle—2 I always use condom—3 Other specify—4 No response—99	

Part four: provider-initiated HIV counseling and testing

	Questions	Coding classifications	rmark
401	Have you ever heard of PITC?	Yes—1 No—2 No response--99	if response is no, go to Q 403
402	If your response to Q 401 is yes, where did you get the information?(multiple response is possible, needs probing)	Health workers—1 Mass media—2 Family member—3 Friends—4 Other(specify)—5 No response—99	
403	Do you agree that any one should check his/her HIV serostatus?	Yes—1 No—2 No response--99	
404	To what extent are you in favor of PITC?	Extremely in favor—1 Very much—2 Some what—3 Not at all—4 No response—99	
	Did you feel that PICT is important?	Yes—1 No—2 No response--99	
406	If your response to Q405 is yes, what are the reasons for feeling that PITC is important?	Helps TB patients get access to ART—1 Makes easier for TB patients to get tested----------2 Results in less discrimination (bad treatment) of HIV positive TB patients -------3 Increase number of tested people ----------4 Other(specify)----------5 No response----------99	
407	Did you accept PITC?	Yes—1 No—2 No response--99	
408	If your response to Q407 is yes, what are the Reasons for feeling that PITC has influence?	Will cause TB patients to avoid Seeing health professionals for fear of being tested—1 Violet TB patients human right –2 Leads to more	

		violence against women—3 It has no influence-4 Other-5 No response—99	
409	At which time should one be tested for HIV? (multiple response is possible, needs probing)	When one is sick—1 Before marriage—2 If only has multiple partners—3 At any time—4 Other(specify)—5 No response--99	
410	Who are people in need of HIV test?(multiple response is possible, needs probing)	Female commercial sex workers—1 Drivers—2 People with history of unprotected sex—3 TB patients—4 Those with multiple partners—5 Any one sexually active—6 Those who are sick—8 Other(specify)—9 No response--99	
411	I don't want to know the result, but have you ever been tested for HIV?	yes—1 no—2 No response--99	
412	If your response to Q411 is yes, what was the reason of having HIV test?	Voluntary testing by your self—1 Initiated by health worker—2 Donation of blood—3 Infected with TB –4 Other(specify)—5 No response--99	
413	If your response to Q 411 is yes, when did you do your last test for HIV?	Before my illness—1 After my illness—2 Other(specify)—3 No response—99	
414	If your response to Q411 is yes, where did you do your test?	Your TB treatment center—1	

		Other health facilities--------2 Free standing VCT centers—3 Other(specify----------4 No response----------99	
415	If your response to Q411 is no ,what are your reasons for not to be tested?(multiple response, needs probing)	Fear of stigma and discrimination follow the positive result—1 Fear of partner's reaction—2 Unable to cope with the positive result—3 I am not risk person for HIV—4 Difficult to pay for VCT service—6 Absence of VCT center in TB treatment center--7 Belief as begin tested is not useful—8 Not sure of the confidentiality—9 Don't want to know the result—10 Partners trust—11 Self trust—12 Other(specify)--13 No response--99	
416	Did your TB treatment supervisor initiate you for HIV counseling and testing any time during your TB treatment follow up?	Yes—1 No—2 No response—99	if response is no, stop here
417	If your response to Q416 is yes, I don't want to know the result, but have you had HIV counseling and testing following your supervisor initiation?	Yes—1 No—2 No response—99	
419	If your response to Q417 is yes, did you receive information before testing?	Yes—1 No—2 No response—99	
420	If your response to Q417 is yes, were you satisfied with HIV counseling you received?	Yes—1 No—2 No response—99	
421	If your response to Q417 is yes, don't tell me result; do you know the result of your test?	Yes—1 No—2 No response—99	
422	If your response to Q417 is no, what were your reasons for not to	Fear of stigma and discrimination following the	

	be tested?(multiple response is possible, needs probing)	positive result----------1 Fear of partner's reaction—2 Unable to cope with the positive result----------3 I am not risk person for HIV-4 Fear of discrimination(bad treatment) by health providers----------5 No access to good quality clinic----------6 Other people advised not to test----------7 Belief as being tested is not useful----------8 Not sure of thconfidentiality-9 Don't want to know thresult10 Partners trust----------11 Tested before----------12 Other(specify)----------13 No response----------99	

Do you have any question?

That is the end of our interview. Thank you very much for taking time to answer these questions.

Structured Amharic Version Questionnaire

አዲሲ ኮንቲነታል ኢንስቲቲዮት ኦፍ ፐብሊክ ሄልዝ ኤንድ ዩኒቨርስቲ ኦፍ ጉንደር

<u>ቃለ መጠየቅ ከመደረጉ በፊት የተሳታፊዎችን ፍቃደኝነት ማረጋገጫ ቅጽ</u>

አዲስ አበባ ውስጥ ባሉት የጤና ድርጅቶች የሳንባ ነቀርሳ/ቲቢ በሽታ ህክምናቸውን በመከታተል ላይ ለሚገኙት ህመማን በጤና ባለሙያ አነሳሽነት ለሚደረግ የኤች አይ ቪ ምርመራና ምክር አገልግሎት አቀባበል ሁኔታ የተመለከተ ጥናት፡፡

1/ የህክምናው ማዕከል ስም----------

2/ የመጠይቁ መለያ ቁጥር ----------

<u>መግቢያ</u>

ስሜ ----------ይባላል፡፡ በአዲስ ኮንቲነታል የህብረተሰብ ጤና ትምህርት ክፍል ተማሪ ስሆን በ---------- ሆስፒታል የሳንባ ነቀርሳ/ቲቢ በሽታ ህክምናቸውን በመከታተል ላይ ለሚገኙት ሕመማን በጤና በለሙያ አነሳሽነት ለሚደረግ የኤች አይ ቪ ምርመራና ምክር አልግሎት መጠይቆችን እጠይቃለሁ፡፡ እርስዎ ለዚህ ጥናት ተሳታፊ እንዲሆኑ ተመርጠዋል፡፡ ይህ ጥናት የሚካሄደው በቃለ መጠይቅ ሲሆን በቃለ መጠይቁ ላይ ስም አይመዘገብም በቃለ መጠይቅ የሚሰጡት መረጃ ሁሉ በሚስጥር የሚያዝ ነው፡፡ እርስዎ በዚህ ጥናት ላይ የመሳተፍ ያለመሳተፍ ወይም በማንኛውም ወቅት ቃለ መጠይቁን የማቋረጥ ሙሉ መብትዎ የተጠበቀ መሆኑን አረጋግጥሎታለሁ፡፡ ሆኖም በአለመሳተፎ በሚያገኙት አገልግሎት ላይ ምንም አይነት ተጽዕኖ አይኖረውም፡፡ ነገር ግን እርስዎ በጥናቱ ተሳትፈው የሚሰጡን መረጃ አገልግሎት አሰጣጥ ላይ ለውጥ ለማምጣት ከፍተኛ ጠቀሚታ ይኖረዋል ተብሎ ይታመናል፡፡

የነገርክዎትን በትክክል ተረድተዋል?

1/ አዎን 2/ የለም

በጥናቱ ላይ ለመሳተፍ ፈቃደኛ ነዎት

1/አዎን 2/ አይደለሁም

3. ፍቃደኛነቱን ያረጋገጠው መረጃ ሰብሳቢ

ሀ/ ሙሉ ስም ----------ፊርማ----------

ለ/ ኮድ ----------

ሐ/ ቀን ----------ወር ----------

2001ዓ/ም

4. ውጤት

ሀ/ የተጠናቀቀ **ለ/ በከፊል የተመለሰ**

ሐ/ ተጠያቂው ፍቃደኛ አይደለም **መ/ ሌላ ካለ ይገለጽ**

5. የተቆጣጣሪው ስም ---------- ፊርማ----------ቀን ---

<u>ማሳሰቢያ</u>

1. ግለሰቦች በመጠይቁ ለመሳተፍ ምንም አይነት ማስገደጃ ወይም ጫና ማድረግ አያስፈልግም።

2. በጥናቱ ለመሳተፍ ፍቃደኛ ከልሆነ/ች የግለሰቡን እድሜ እና ፆታ ይመዝግቡ፡

ክፍል አንድ፡- ስለማህበራዊ ሁኔታ የሚያመለክቱ ጥያቄዎች

/ቁ	ጥያቄዎች	መልስ ሊሆኑ የሚችሉ		አስተያየት
101	አድሜዎ ስንት ነው?	------- ዓመት/ በሙለ ዓመት ይገለጽ		
102	የተጠያቂው ጸታ	ወንድ	1	
		ሴት	2	
103	ሐይማኖትዎ ምንድነው?	ኦርቶዶክስ	1	
		ሙስሊም	2	
		ፕሮቴስታንት	3	
		ካቶሊክ	4	
		ሌላ ካለ ይገለጽ	5	
		መልስ የለም	99	
104	በአሁኑ ወቅት የጋብቻ ሁኔተዎ አንዱት ነው?	ያገቡ	1	
		በጭራሽ ያላገቡ	2	
		የተፋቱ	3	
		ባል/ሚስት የሞተባቸው	4	
		ያልተጋቡ ጥንዶች	5	
		ለጋብቻ ያልደረሱ	6	
105	ተምረው የጨረሱት ከፍተኛ ው የትምህርት ደረጃ ስንት ነው?	---------- ክፍል ያጠናቀቁ	1	
		ማንበብና መፃፍ ብቻ የሚችሉ	2	
		ማንበብና መፃፍ የማይችሉ	3	
		መልስ የለም	99	

106	በአሁኑ ወቅት ያለዎት የስራ አይነት ምንድ ነው?	የመንግስት ሠራተኛ	1	
		የቤት እመቤት	2	
		የቀን ሠራተኛ	3	
		የቤት ሠራተኛ	4	
		የቡና ቤት ሠራተኛ	5	
		ተማሪ	6	
		ነጋዴ	7	
		ሥራ የሌለው	8	
		ሌላ ካለ ይግለፁ	99	

107	ጠቅላላ የቤተሰብ አማካይ የወር ገቢ ስንት ነው? (የባለቤትዎንና የርስዎን ጨምረው)	የኢት ብር ----- ------	1	
		ገቢ የሌለው	2	
		አላውቅም	88	
		መልስ የለም	99	
108	የቤተሰብ አባላት ብዛት ስንት ነው?	ቁጥር----------		
		መልስ የለም	99	
109	ከቤተሰብዎ ወስጥ የቲቢ በሽታ ህክምና የወሰደ አለ/ ከአሁን በፊት ወይም አሀን/?	አዎ	1	
		የለም	2	
		መልስ የለም	99	

ክፍል ሁለት በኤች አይ ቪ ኤድስና ቲቢ ያለዎት እውቀት/ አስተያየት

/ቁ	ጥያቄዎች	መልስ ሊሆኑ የሚችሉ ዝርዝሮች		አስተያየት
201	በሳም ባ ነቀርሳ/ቲቢ በሽታ እያዛለሁ የሚል ስጋት ነበርዎት?	አዎ	1	
		የለኝም	2	
		መልስ የለም	99	
202	የሳመ ባ ነቀርሳ/ቲቢ በሽታ እንዳለቦዎት ለሰዎች ይናገራሉ?	እናገራለሁ	1	
		አልናገርም	2	
		መልስ የለም	99	
203	በርሶ ም አመለከከት /ዕይታ ለሳምባ ነቀርሳ/ቲቢ በሽታ በተለየ መልኩ ተጋላጭ የሆነ የህብረተሰብ ክፍል የትኛው ይሆናል ብለው ያምናሉ? (ከአንድ በላይ መልስ ይቻላል አንብበው የሚሰጡትን ሁሉ መልስ አክብቡ)	ድሀው ህብረተሰብ	1	
		ከቲቢ ህመማን ጋር የሚኖረው ሰው	2	
		ከኤች አይቪ ኤድስ ጋር የሚኖር ሰው	3	
		ሌላ ካለ ይገለጽ	4	
		መልስ የለም	99	
204	አንድ ሰው የሳንባ ነቀርሳ በሽታ ከየት ሊይዘው ይችላል (ከአንድ በላይ መልስ ይቻላል:: የሚሰጠትን ሁሉ መልስ አክብበው)	ከቲቢ በሽተኛ	1	
		ከጤና ባለሙያዎች/ተቋማት	2	
		ከተበከለ አየር	3	
		ከተበከለ ውሃ	4	
		ከግብረ ስጋ ግንኙነት	5	
		ከርኩስ መንፈስ	6	
		ሌላ ካለ ይገለጽ	7	
		መልስ የለም	9	
205	የሳም ባ ነቀርሳ/ቲቢ በህክምና ሊድን/ሊፈወስ ይችላል?	አዎን ይችላል	1	
		ሊፈወስ አይችልም	2	
		ሌላ ካለ ይገለጽ	3	
		መልስ የለም	99	
206	የኤች አይ ቪ/ኤድስን	አዎን ጨምሮል	1	

	በሽታ ከተከሰተ ወዲህ የሰንባ ነቀርሳ/ቲቢ በሽታ ጨምሮል ብለው ያምናሉ?	የለም	2	
		አላውቅም	3	
		መልስ የለም	99	
207	ኤች አይቪ/አድስን መቆጣጠር ቲቢን ለመቆጣጠር ይረዳል ብለው ያስባሉ?	አዎን ይረዳል	1	
		አይረዳውም	2	
		አላውቅም	3	
		መልስ የለም	99	
208	ስለኤች አይ ቪ ኤድስ በሽታ ሰምተው ያውቃሉ?	አዎ ሰምቻለሁ	1	
		አልሰማሁም	2	
		መልስ የለም	99	
209	የኤች አይ ቪ ኤድስ ይድናል ብለዉ ያስባሉ?	አዎ ይድናል	1	
		አይድንም	2	
		መልስ የለም	99	
210	የኤች አይ ቪ ኤድስ በሽታ በምን መንገድ ሊተላለፍ ይችላል ? **ከአንድ በላይ መልስ ይቻላል አንብበው የሚሰጡትን ሁሉ መልስ አክብበው/**	በግብረ ስጋ ግንኙነት	1	
		ከናት ወደ ጽንስ በርግዝና ጊዘ ፡	2	
		ከናት ወደ ልጅ በጡት ማጥባት	3	
		በኤች አይቪ ኤድስ የተበከለ ደም መቀበል	4	
		ኤች አይቪ ኤድስ ከያዘው ሰው ጋር በጋራ ስለታም ነገሮችን መጠቀም	5	
		መጨባበጥ	6	
		የኤች አይቪ ኤድስ በሽተኛ ልብሶችን መልበስ	7	
		ኤች አይቪ ኤድስ ከያዘው ሰው ጋር አብሮ መመገብ	8	
		በወባ ትንኝ	9	
		በደም ንክኪ	10	
		ሌላ ካለ ይገለጽ	11	
		መልስ የም	99	
211	አንድ ሰው በኤች አይ ቪ ኤድስ እንዳይያዝ በምን መንገድ መከላከል ይቻላል ? **ከአንድ በላይ መልስ ይቻላል አንብበው የሚሰጠትን ሁሉ መልስ ያክብቡ**	ከግብረ ስጋ ግንኙነት በመቆጠብ	1	
		ግብረስጋ ግንኙነት በፈጸሙ ቁጥር ኮንዶም መጠቀም	2	
		ከበሽታ ነፃ ከሆነ/ች ጋር አንድ ለአንድ መወሰን	3	
		ሌላ ካለ ይጠቀስ	4	
		አላውቅም	88	

		መልስ የለም	99	
212	ከኤች አይ ቪ ጋር የሚኖር አልያም በኤድስ በሽታ የታመመ ወይም በበሽታው የሞተ ሰው ያውቃሉ ?	አውቃለሁ	1	
		አላውቅም	88	
		መልስ የለም	99	
213	ጤነኛ የሚመስሉ ሰዎች የኤች አይ ቪ ቫይረስ ሊኖርባቸው ይችላል ?	ይችላል	1	
		አይችልም	2	
		አላውቅም	88	
		መልስ የለም	99	

ክፍል ሶስት ስለ ኤች አይ ቪ ኤድስ የመጋለጥ ግላዊ ዕሳቤ

/ቁ	ጥያቄዎች	መልስ ሊሆኑ የሚችሉ ዝርዝሮች		አስተያየት
301	የኤች አይ ቪ ቫይረስ ሊይዘኝ ይችላል ብለው ያስባሉን ?	አዎ	1	መልሱ አዎ ከሆነ ወደ 303 ይሂዱ
		አላስብም	2	
		መልስ የለም	99	
302	የራስ ዎ የኤች አይ ቪ/ኤድስ ተጋላጭነት ምን ያህል ይመስልዎተል ?	አነስተና ተጋላጭ ነኝ	1	
		መካከለኛ ተጋላ ነኝ	2	
		በጣም ተጋላጭ ኝ	3	
		ተጋቁጭ አይደለሁም	4	
		መልስ የለም	99	
303	የጥያቄ 301 መልስ አዎ ከሆነ ምክንያቱ ምንድን ነው ?	ያለ ኮንዶም የግብረ ስጋ ግንኙነት ስለፈጸምኩ	1	
		ኤች አይቪ ፓዘቲቭ ከሆነ ሰው ጋር ግብረ ስጋ ግንኙነት ስለፈጸምኩ	2	
		ብዙ የወሲብ ጓደኖች ስለነበሩኝ	3	
		ሌላ ሰው በተጠቀመበት መርፌ ስለተጠቀምኩ	4	
		ሌላ ካለ ይጥቀሱ	5	
		መልስ የለም		

ክፍል አራት፡- በጤና ባለሙያ አነሳሽነት ላይ የተመሰረተ የኤች አይ ቪ ምርመራና ምክር አገልግሎት አጠቃቀም

/ቁ	ጥያቄዎች	መልስ ሊሆኑ የሚችሉ		አስተያየት
401	በጤና ባለሙያ አነሳሽነት ላይ የተመሠረተ የኤች አይ ቪ ኤድስ ምርመራና ምክር አገልግሎት መኖሩን ስምተው ያውቃሉ?	ሰምቻለሁ	1	አልሰማሁም ከሆነ ወደ 403 ይሁዱ
		አልሰማሁም	2	
		መልስ የለም	9	
402	ለቁጥር 401 መልሱ ሰምቻለሁ ከሆነ መረጃው ከየት ነው ያገኙት	ከጤና ባለሙያዎች	1	
		ከብዙሃን መገናኛ	2	
		ቤተሰብ	3	
		ከጓደኛ	4	
		ከሌላ ካለ ይጥቀሱ	5	
		መልስ የለም	99	
403	ማንኛውም ሰው የኤች አይ ቪ ምርመራ ማድረግ አለበት ብለው ያስባሉ?	እጅግ በጣም	1	
		በጣም	2	
		በመጠኑ	3	
		አልደግፍም	4	
		መልስ የለም	99	
404	በጤና ባለሙያ አነሳሽነት ላይ የተመሰረተ የኤች አይ ቪ ምርመራና ምክር አገልግሎትን ምን ያክል ይደግፋሉ?	እደግፋለሁ	1	
		አልደግፍም	2	
		መልስ የለም	99	
405	በጤና ባለሙያ አነሳሽነት ላይ የተመሰረተ የኤች አይ ቪ ምርመራና ምክር አገልግሎት ጠቃሚነው ብለው ያስባሉ?	አዎ	1	መልሱ አዎ ከሆነ ወደ 406 ይሂዱ
		አይጠቅምም	2	
		አላውቅም	3	
		መልስ የለም	99	
406	በጤና ባለሙያ አነሳሽነት ላይ የተመሰረተ የኤች አይ ቪ ምርምና ምክር አገልግሎት ለቲቢ ህሙማን መጀመሩ ምን ጥቅም አለው ብለው ያስባሉ	የቲቢ ህሙማን የፀረ ኤች አይቪ መድኒት እንዲያገኙ ይረዳል፡፡	1	
		ቲቢ ህሙማን በቀላሉ እንዲመረመሩ ያደርጋል	2	
		ኤች አይቪ ፓዘቲቭ የሆኑ ቲቢ ህሙማን ህክምና ላይ የሚደረግ አድልዎ ይቀንሳል	3	

		የተመርማሪው ቁጥር እንዲጨምር ያደርጋል	4	
		ሌላ ካለ ይግለፁ	5	
		አላውቅም	88	
		መልስ የለም	99	
407	በጤና ባለሙያ አነሳሽነት ላይ የተመሰረተ የኤች አይ ቪ ምርመራና ምክር አገልግሎት ተቀብለዉ ያዉቃሉ?	አዎ	1	
		አላውቅም	88	
		መልስ የለም	99	
408	**በቁጥር 407 መልስ አዎ ከሆነ** በጤና ባለሙያ አነሳሽነት ላይ የተመሰረተ የአች አይ ቪ ምርመራና ምክር አገልግሎት መጀመሩ ምን ተዕጽኖ ይኖረዋል ብለው ያስባሉ?	ቲቢ ህመማን የኤች አይቪ ምርመራን በመፍራት ወደ ህክምና ማዕከል እንዳይሄዱ ያደርጋል	1	
		የቲቪ ህመማን ስብአዊ መብት ሊጥስ ይችላል	2	
		በሴቶች ላይ ጸታዊ ጥቃት እንዲደርስ ያደርጋል	3	
		ምንም ዓይነት ተዕዕኖ የለውም	4	
		ሌላ ካለ ይጠቀስ	5	
		መልስ የለም	99	
409	አንድ ሰው የኤች አይ ቪ ምርመራ ማድረግ ያለበት መቼ ነው? **(ከአንድ በላይ መልስ ይቻላል አንብበው የሚሰጠትን መልስ አክብብ)**	ሲታመም	1	
		ከጋብቻ በፊት	2	
		ከአንድ በላይ ወሲብ ጓደኛ ሲኖረው	3	
		በማንኛውም ጊዜ	4	
		ሌላ ካለ ይግለጽ	5	
		መልስ የለም	99	
410	የኤች አይ ቪ ምርመራ የሚያስፈልገው ለማን ነወ ይላሉ **ከአንድ በላይ መልስ ይቻላል አንብበው የሚሰጠትን መልስ አክብብ**	ለሴተኛ አዳሪዎች	1	
		ለሹፌሮች	2	
		ያለኮንዶም ግብረስጋ ግንኙነት ያደረገ/ች	3	
		ህመማን	4	
		ለአቅመአዳም የደረሰ/ች	5	
		የቲቪ ህመምተኞች	6	
		ሌላ ካለ ይጥቀሱ	7	
		መልስ የለም	99	
411	የእርሶን የምርመራውን ውጤት ማወቅ አልፈልግም:: ግን የኤች አይ ቪ ምርመራ አድርገው ያውቃሉ?	ተመርምሬ አውቃለሁ	1	
		ተመርምሬ አላውቅም	2	
		መልስ የለም	99	
412	**በቁጥር 411 መልስዎ አዎ ከሆነ** በምን	በራስ ፍላጎትና ጥያቄ	1	

	ምክንያት ነበር የኤች አይ ቪ ምርመራ ያደርጉት?	በጤና ባለሙያዎች ትዕዛዝ	2	
		የደም ልገሳ ለማድረግ	3	
		ለጋብቻ	4	
		ሌላ ካለ ይጥቀሱ	5	
		መልስ የለም	99	
413	በቁጥር 411 መልስዎ አዎ ከሆነ የመጨረሻውን የኤች አይ ቪ ምርመራ ያደረጉት መቼ ነው?	በቲቢ በሽታ ከመታመሜ በፊት	1	
		በቲቪ በሽታ ከታመምኩ ቡኋላ	2	
		መልስ የለም	99	
414	በቁጥር 411 መልስዎ አዎ ከሆነ የኤች አይ ቪ ምርመራ የት ነበር ያደረጉት?	የቲቪ ህክምና በሚከታተሉበት የጤና ድርጅት	1	
		ሌላ የጤና ድርጅት	2	
		ለኤች አይቪ ምርመራ አገለግሎት ብቻ በሚሰጥ ድርጅት	3	
		ሌላ ካለ ይጠቀስ	4	
		መልስ የለም	99	
415	በቁጥር 411 መልስዎ ተመርምሬ አላውቅም ከሆነ በምን ምክንያት ነው የኤች አይ ቪ ምርመራ ያላደረጉት **(ከአንድ በላይ መልስ ይቻላል አንብበው የሚሰጡትን ሁሉ መልስ አክብበው)**	ድልአና መገለልን በመፍራት	1	
		ቫይረሱ ቢኖርብኝ የጓደኛ ቁጣ በመፍራት	2	
		ውጤት ለመቀበል ስለምፈራ	3	
		ኤች አይቪ ይይዘኛል ብዬ ስለማላስብ	4	
		የኤች አይቪ ምርመራ ዋጋ መክፍል ስለማልችል	5	
		በቲቢ የህክምና ማዕከል የኤች አይቪ ምርመራና ምክር አገልግሎት ስለሌለ	6	
		መመርመር ጥቅም አለው ብዬ ስለማላምን	7	
		ሚስጥርነቱ መጠበቁን ስለምጠራጠር	8	
		ውጤቱን ማወቅ ስለማልፈልግ	9	
		ጓደኛዬ ስለተመረመረ	10	
		ሌላ ካለ ይጠቀስ	11	
		መልስ የለም	99	
416	የቲቢ ህክምናውን ክትትል የሚያደረግልዎ የጤና ባለመያ የኤች አይ ቪ ምክርና ምርመራ አንዲያደርጉ አነሳስተዎት ያወቃሉ?	ያውቃል	1	
		አያውቁም	2	
		መልስ የለም	99	
417	**ለቁጥር 416 መልሱ ያውቃል** ከሆነ የምርመራ ውጤቱን ማወቅ አልፈልግም ነገር ግን	አዎ	1	
		አላደረኩም	2	

	በጤና ባለሙያው አነሳሽነት የኤች አይ ቪ ምርመራ አድርገዋል?	መልሱ የለም	99	
418	ለቁጥር 417 መልሱ አዎ ከሆነ ከምርመራው በፊት ስለ ምርመራው ተነግሮዋል ?	አዎ	1	
		አልተነገረኝም	2	
		መልስ የለም	9	
419	ለቁጥር 417 መልሱ አዎ ከሆነ ከምርመራው በኋላ የምክር አገልግሎት ወስደዋል?	አዎ	1	
		አልወሰድኩም	2	
		መልስ የለም	9	
420	ቁጥር 417 መልሱ አዎ ከሆነ የምርመራ ውጤቱን ማወቅ አልፈልግም ነገር ግን የኤች አይ ቪ ምርመራ ወጤትዎን አውቀዋል?	አውቂያለሁ	1	
		ውጤት አላወኩም	2	
		መልስ የለም	99	
421	በቁጥር 417 መልስዎ አላደረኩም ከሆነ በምን ምክንያት ነው ምርመ ራ ያለደረጉት	አድሎና መገለልን በመፍራት	1	
		ቫይረሱ ቢኖርብኝና የጓደኛ ቁጣ በመፍራት	2	
		ውጤትን ለመቀበል ስለምፈራ	3	
		ኤች አይቪ ይይዘኛል ብዬ ስለማላስብ	4	
		የጤና ባለሙያዎች አድሎ/ጥሩ ያልሆነ ህክምና/ ይደርስብኛል ብዬ ስለምፈራ	5	
		ጥሩና ጥራት ያለው የህክምና አገልግሎት አቅርቦት ስለሌለ	6	
		ሌሎች ሰዎች እንዳልመረመር ስለመከሩኝ	7	
		ሚስጥርነቱ መጠበቁን ስለምጠራጠር	8	
		ውጤቱን ማወቅ ስለማልፈልግ	9	
		ጓደኛዬ ስለተመረመረ	0	
		ተመርምሬ ስለማውቅ	11	
		ሌላ ካለ ይጠቀስ	12	
		መልስ የለም	99	

ጥያቄ አለዎት? ቃለ መጠይቁን እዚህ ላይ እንጨርሳለን:: ቃለ መጠይቁን ለማድረግ ስለተባበሩን ከልብ እናመሰግናለን::

ጤና፡ይሰጥልኝ

ሰሜ፡ ስናይት፡ገብረየሱስ፡ ይባላል፡፡

በአዲስ፡ ኮንቲነንታል፡ የህብረተሰብ፡ ጤና ትምህርት፡ ክፍል ተማሪ ነኝ ፡፡

ከእርሶ ጋር በ ጤና ባለሞያ አነሳሽነት በሚደረግ የኤች አይ ቪ ምርመራና ምክር አልግሎት መጠይቆችን እጠይቃለሁ፡፡ እርስዎ ለዚህ ጥናት ተሳታፊ እንዲሆኑ ተመርጠዋል፡፡ ይህ ጥናት የሚካሄደው በቃለ መጠይቅ ሲሆን በቃለ መጠይቁ ላይ ስም አይመዘገብም በቃለ መጠይቅ የሚሰጡት መረጃ ሁሉ በሚስጥር የሚያዝ ነው፡፡እርስዎ በዚህ ጥናት ላይ የመሳተፍ ያለመሳተፍ ወይም በማንኛውም ወቅት ቃለ መጠይቁን የማቋረጥ ሙሉ መብትዎ የተጠበቀ መሆኑን አረጋግጥሎታለሁ፡፡ ሆኖም በአለመሳተፎ በሚያገኙት አገልግሎት ላይ ምንም አይነት ተጽዕኖ አይኖረውም፡፡ ነገር ግን ርስዎ በጥናቱ ተሳትፈው የሚሰጡን መረጃ አገልግሎት አሰጣጥ ላይ ለውጥ ለማምጣት ከፍተኛ ጠቀማታ አለው፡፡

1) በህክምና ባለሞያ አነሳሽነት የተመሰረተየኤች አይ ቪ ምርመራ ሰምተው ያውቃሉ?

2) በፈቃደኝነት ላይ የተመሰረተየኤች አይ ቪ ምርመራና በባለሞያ አነሳሽነት በሚደረግ ምርመራ ያለውን ልዩነት ሊነግሩኝ ይችላሉ?

3) ማንኛውንም አይነት የኤች አይ ቪ ምርመራ ከዚህ በፊት አድርገው ያውቃሉ?

4) ምርመራውን እዲያደርጉ ጥያቄ የቀረበልዎት እንዴት ነበር? በግ ዴታ መልኩ ነው? እንዲያደርጉ ጫና ነበር? ሃሳብዎትን ለመግለፅ እድሉ ተሰ ጥቶዎት ነበር?

5) ለምርመራ ያነሳሳዎት ምን ነበር? በግልፅ ገብቶዎት ነው? ወይስ የጤና ባለሙያ ስለሆነ ስለእርሶ መወሰን ይችላል ብለው ነው?

6) ለመመርመር ሙሉ ፍላጎት ነበረዎት ወይስ እምቢ ብል በቀጣዩ ህክምዮ እና ግንኙነቴ ችግር ይኖረዋል ብለው እስበው ነው?

7) ከተመረመሩ በሁኋላ ምን ተሰማዎት? ተቆጨ? ምነው ባልተመረመርኩ ብለው?

8) ተመርምሮ ውጤትን ማውቁ ምን ይጠቅማል ብለው ያስባሉ?

9) የምርመራ ውጤትዎትን ለማሳወቅ እቅድ አለዎት? ከለዎትስ ለማን ማሳወቅ አስበዋል?

10) ለማሳወቅ ሃሳብ ከሌለዎትስ ለምን? ምን ይደርስብኛል ብለው በማስብ ነው?

ጤና፡ይሰጥልኝ

ሰሜ፡ ስናይት፡ገብረየሱስ፡ ይባላል፡፡

በአዲስ፡ ኮንቲነንታል፡ የህብረተሰብ፡ ጤና ትምህርት፡ ክፍል ተማሪ ነኝ

ከእርሶ ጋር በ ጤና ባለሞያ አነሳሽነት በሚደረግ የኤች አይ ቪ ምርመራና ምክር አልግሎት መጠይቆችን እጠይቃለሁ፡፡

ባለፉው የከተት ወር መጨረሻእና **በመጋቢት ወር በባለሞያ አነሳሽነት የሚደረግ** የኤች አይ ቪ ምርመራና ምክር አልግሎት ተቀባይነቱ ምን ያህል እንደሆነ በዘውዲቱ እና በቅዱስ ጴጥሮስ ሆስፒታሎች **በተደረጉ ጥናቶች የአመላከተው በአብዛኛው የቲቢ ህመምተኛ** እንድተቀበለው ነው፡፡

በዚህ ምክንያ ቀጣይ ጥናት ማድረግ **አስፍላጊ ሆኑዋል፡፡ ስልዚህ በአንዳንድ ጥያቄዎችና ሃሳቦች ላይ ለመወያየት ፍቃደኛነትዎትን በማከበር እጠይቃለሁ፡፡በቅድሚያ ጊዜአችሁንና ፍቃዳችሁን ስለሰጣችሁኝ**

አመሰግናለሁ፡፡

1) በዚህ፡ ሆስፒታል ቲቢ ክሊኒክ ያልዎትን የስራ ድርሻ ቢነግሩኝ?

2) በክሊኒክችሁ በህክምና ባለሞያዎች አነሳሽነት የተመሰረተየኤች አይ ቪ ምርመራ መቸእንደተጀመረ ቢነግሩኝ?

3) የህመምተኛው አቀባበልስ እንዴት ነው? የባለፍው **አመትንና የአሁኑን ስናወዳድር? እንዲት ይመስላል?**

4) የጤና ባልሞያው ከውንስል ሲያረግ ጫና ያበዛል እንዴ ለህመምተኛው ጥቅም ሲል? መድሀኒቱ በነጽአ ስላል? ወይስ በሽተኛው ሳይጎዳ ከታወቀ ለቀጣዩ ህክምና ጥሩ ውጠት ለማግኝት ስለሚረዳው ነው?

5) እስቲ እንዴት ነወ **እንፎርሜሽኑን የምትነግሮአቸው?** እምቢ የማለት መብት እንዳላቸው ያስረዱአቸዋል? ነው መቀበላቸው ጠቀሜታ እንዳለው ብቻ ነው የሚያስረዱአቸው?

Declaration

I, the undersigned declare that this thesis is my original work in partial fulfillment of the requirement for the degree of Master of Public Health. I also declare that it has never been presented in this or any other university and that all resources and materials used in the thesis have been duly acknowledged.

Student Name: _____

Signature: _____

Place of submission: _____

Date of submission: _____

This thesis has been submitted for examination with my approval as a university advisor.

Advisor Name: _____

Signature: _____

Date of submission: _____